Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014823	A. BUILDING: _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF SOUTH SHORE	2425 EAST 71ST STREET CHICAGO, IL 60649

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S 000	Initial Comments Complaint Investigation 1683536/IL86516 1683616/IL86613 1683642/IL86643	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility,	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect	S9999		

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a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:

Based on interview and record review the facility failed to the plan of care transfer intervention and use (2) person and a mechanical lift while transferring from the wheelchair to the bed for 1 of 3 (R1) reviewed for transfers using a mechanical lift. This failure resulted in R1 sustaining a fractured left leg during a one person transfer from a wheelchair to the bed.

Findings include:

Face Sheet documents R1 was admitted to the facility on 10/19/15 with the diagnosis of brain aneurysm. Minimum Data Set (MDS) 4/4/16 documents R1's transfer status as total dependence by 2 people. Mobility Assessment 4/14/16 documents R1 is assessed as needing a mechanical lift for all transfers. Care Plan 12/14/15 for assistance with activities includes the intervention total assist x 2 staff with transfer (mechanical lift) and transfer from bed to wheelchair and vice versa with use of mechanical lift x 2 staff. Care Card documents R1 is a mechanical lift with 2 people.
Nurse Progress Note 6/28/16 12:29pm documents there are no clean slings for the mechanical lift and R1 will be transferred once a clean sling is available. Incident Report 6/28/16 documents R1 was transferred out of bed by 2 staff members using a gait belt and transferred back to bed by 1 staff member without the use of any assistive devices. After the second transfer,

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R1 complained of pain to the left leg. R1 is assessed with swelling and redness to the left shin and an x-ray is ordered. X-ray results 6/29/16 document a fracture of the left lower leg bones.

On 7/7/16 from 12:30-12:50pm, R1 sat in a wheelchair and had a cast on the left leg, from the mid foot all the way up to the mid-thigh. R1 stated that on 6/28/16 on the 2-10pm shift, Z4(Nurse Aide) and Z5(Nurse Aide) transferred her from the bed to the chair without using the mechanical lift. R1 stated they did not use the lift because there were no pads. The 6am-2pm shift knew this also and did not get R1 up on that shift. R1 stated that later at night, Z3(Nurse Aide) transferred her back to bed by himself, did not use a gait belt, mechanical lift, or another person. R1 asked Z3 not to lift her, but as he did R1's left leg hit or got caught in the siderail. R1 stated she told Z3 and Z5 that her left leg hurts, but the nurse didn't come to check on her until about 11pm. R1 stated "I don't think (Z5) told anyone about the transfer and my leg pain."

The following interviews took place on 7/7/16:
At 10:20am, E2(Director of Nursing) stated Z5 asked Z4 to get R1 up to the chair on 2-10pm shift 6/28/16. Z5 asked Z3 to transfer R1 back to bed around 9pm 6/28/16. After the transfer back to bed, R1 told Z3 and Z5 of pain in the left leg. E2 stated the nurse did not know about R1's pain until about 1 hour later.
At 11:50am, E4(Nurse) stated that on 6/28/16, R1 did not get up in the chair because there were no clean slings for the mechanical lift, and R1 needs the mechanical lift for transfers. E4 stated R1 cannot support her weight and pivot to assist

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during a transfer. E4 stated the female aide on the 2-10pm shift asked why R1 was still in bed. E4 replied that there were no slings for the mechanical lift. E4 stated the facility has a "no lift policy", restorative assesses the patient for transfer status, and it is communicated on the care cards.
At 1:55pm, E3(Nurse) stated that on 6/28/16 at 10:45pm, the night shift aide reported there was something wrong with R1's leg. Upon assessment, R1's left leg had a large bump below the knee and was in a lot of pain. E3 stated she called the physician, gave Tylenol, applied an ice pack, elevated the ;leg, and ordered an x-ray. E3 asked R1 what happened, and R1 replied that her left leg hit the siderail when Z3 put her back to bed. E3 stated sometimes slings for the mechanical lifts are not available, but R1 should not have been transferred without the mechanical lift.

The following interviews took place on 7/13/16:
At 12:25pm, Z4 stated R1 did not have a fall, R1 was transferred out of bed to the wheelchair by Z4 and Z5 using a gait belt. Z4 stated he knew R1 needed a mechanical lift, but thought it was OK to use 2 people plus a gait belt. Z5 did not tell Z4 why the mechanical lift was not used.
At 1:20pm, E6(Nurse) stated she worked 11pm-7am on 6/28/16. E6 stated R1 was very upset about having a broken leg from the transfer.
At 1:35pm, Z3 stated that on 6/28/16, R1 was transferred only by him around 9:45pm; Z3 put his arms underneath R1's arms and lifted her into the bed. After the transfer, R1 told Z5 that her leg hurts. Z3 stated he saw Z5 look at R1's leg, but then Z5 did not tell the nurse before leaving at the end of the shift.
At 3:35pm, Z5 stated she assisted Z4 with R1's

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transfer from bed to wheelchair; they used 2 people and a gait belt because there were no clean slings for the mechanical lift, which happens "all the time". Z5 stated if the aides can lift the patients, they don't use the mechanical lift if there are no slings available. Z5 stated R1 complained of left leg pain after the transfer, Z5 looked at it but did not see anything. Z5 stated she did not tell anyone that R1's leg hurt; Z5 already left at 10pm and "it slipped my mind".

On 7/14/16 at 10:45am, Z1(Physician) stated R1's fracture happened during the transfer by 1 nurse aide. R1 hit her left leg on the siderail during the transfer. Z1 stated R1 should not have been transferred by 1 person, R1 is totally dependent for transfers and cannot support her weight on her legs to perform a transfer.

The incident investigation was reviewed and staff written statements are consistent with interviews conducted during the complaint survey.

Safe Patient Lifting Policy - The Safe Patient Lifting Policy exists to ensure a safe working environment for resident handlers. The policy is to be reviewed and signed by all staff that perform or may perform resident handling. Initial screen will be performed on all residents to assess transfer and ambulation status. Disciplinary Actions: This policy is to be followed at all times.

(B)